Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

R EDWARD ROYBAL, MD
P.O. BOX 741865
DALLAS, TX 75374

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-11-3251-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: From Table of Disputed Services: "CARRIER IS REQUIRED TO PAY DD EXAMS." and "AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CLAIM NON-COMPENSABLE Denied per the adjuster"

Response Submitted by: Specialty Risk Services, 1851 East 1st St #200, Santa Ana, CA 92705

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2011	99456-WP-NM and 99456-RE-W8	$850.00	$850.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated May 31, 2011
   - 214 – Workers Compensation claim adjudicated as non-compensable. This payor not liable for claim or service/treatment. Services denied. Please contact the SRS Claims Examiner regarding these charges.

Issues

1. Has the Designated Doctor examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent on the EOB dated May 31, 2011 lists the denial reason "214 – Workers Compensation claim adjudicated as non-compensable. This payor not liable for claim or service/treatment. Services denied. Please contact the SRS Claims Examiner regarding these charges." This denial reason is not supported by any claim history of a Plain Language Notice (PLN-11) for this injury prior to DD examination. A MFDR review of this dispute will proceed according to applicable fee guidelines found in 28 Texas Administrative Code §134.204 and per the Texas Labor Code §408.0041 which states in (h)(1):

   (h) The insurance carrier shall pay for:
   (1) an examination required under Subsection (a) or (f).

   and the Texas Labor Code §408.0041 states in part (a)(2) and (5):
   (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:
   (2) the attainment of maximum medical improvement;
   (5) the ability of the employee to return to work; or

2. The requestor billed the amount of $650.00 for CPT code 99456-W5-NM for a DD examination. Documentation submitted supports that MMI was not achieved by the injured worker. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for determination of MMI status is $350.00. The requestor also billed $500.00 for CPT code 99456-RE-W8 for a Return to Work (RTW) examination. Review of documentation supports that the Division ordered the examinations. Per 28 Texas Administrative Code §134.204(i)(2)(A) & (k), the MAR for the 1st Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination is $500.00. The combined MAR for the RTW and MMI examinations is $850.00 which is therefore the amount recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $850.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $850.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 23, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.